Proof of death/Physician's statement

Sun Life Financial

Sun Life Assurance Company of Canada
227 King Street South, PO Box 1601 Stn Waterloo, Waterloo, ON N2J 4C5

1 Details

The claimant is responsible for any fee for this information. Please note that we will only accept an original of this form.

Policy number(s)		
Deceased's first name	Middle initial	Last name

1.1 Place of death	1.2 Date of death (dd-mm-yyyy)	1.3 Date of birth (dd-mm-yyyy)
	– –	– –

1.4 Cause of death	1.5 Date of first onset of symptoms (dd-mm-yyyy)
	– –
1.6 Disease, injury or condition directly leading to death	1.7 Date of first onset of symptoms (dd-mm-yyyy)
	– –

1.8 Date deceased was advised of disease or condition directly leading to death (dd-mm-yyyy)	1.9 Have you treated or advised the deceased during the last 5 years, before his/her last illness? ☐ Yes ☐ No
– –	
1.10 Indicate date you first saw the deceased (dd-mm-yyyy)	1.11 Indicate date you last saw the deceased (dd-mm-yyyy)
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1.12 Give details including **conditions** and **dates** whether or not related to cause of death

1.13 Did the deceased receive treatment during the last 5 years, from any other physician, or in any hospital or facility? ☐ Yes ☐ No
If "yes" give details including **name of doctor, name of hospital or facility, condition** and **dates** whether or not related to cause of death

1.14 Was death due to accident, suicide, or homicide? ☐ Yes ☐ No If "yes", please indicate	1.15 Was an autopsy performed? ☐ Yes ☐ No
1.16 Did the deceased, to your knowledge, ever smoke or use tobacco, tobacco cessation or marijuana products? ☐ Yes ☐ No ☐ Unknown	1.17 Did the deceased ever stop smoking? ☐ Yes ☐ No ☐ Unknown If "yes", when and for how long?

2 Acknowledgement

By signing below you acknowledge that Sun Life Assurance Company of Canada may disclose the information you've provided about the deceased to the claimant or anyone the claimant authorizes. If you believe disclosure has a significant likelihood of a substantial adverse effect on the claimant's health or could harm a third party, please tell us in writing so that we can determine how to release the information.

Last name of physician completing this form (please print)	First name	
Address (street number and name)		Apartment or suite
City	Province	Postal code
Physician's telephone number – –	Physician's fax number – –	
Physician's signature X		Date (yyyy-mm-dd) – –